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HISTORY OF MENTAL CONCEPTS

A conceptual history of Anorexia Nervosa: specificity of the psychopathological perspectives

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Purpose. *To show the contribution of different psychopathological stances in shaping the concept of anorexia nervosa through history.*

Methods. *Description of the most relevant observations of clinical cases, from XVIII to early XX century.*

Results. *The clinical descriptions were shaped by the clinical questions the physicians wanted to investigate. We found medical and psychopathological questions. The former focused on somatic differential diagnosis, measurement of bodily signs and symptoms, organic etiologic explanations, and medical (also behavioral) remedies. The latter studied the psychic phenomena in detail, tried to understand the link between symptoms, settled explanatory hypotheses about the individual, familial, experiential and situational factors leading to eating disturbances, and illustrated various strategies of "moral", behavioral, and psychological treatment. Within the psychopathological approach there were at least three stances, based on the main nosographical constructs operating as "psychopathological attractors": Hysteria (Mid XIX Century), Psychasthenia (End of XIX Century), and Schizophrenia (First half of XX Century).*

Conclusion. *There was an interplay between the different presentation of symptoms in patients and the different theoretical/nosological views of the clinicians. At one side, the different views of the observer entailed different attention to this or that phenomenon (consequently over or under detected), different interpretations of the same phenomenon, etc. At the other side, the patients' phenomena were partly different, and the symptoms of Anorexia as we currently conceive it emerged slowly. In every new description a detail emerged, while other phenomena previously noted were no more reported, so while something was unveiled, something was concealed.*

Keywords: History of Psychiatry; Psychopathology; Anorexia; Bulimia; Eating Disorders

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INTRODUCTION

This is not the history of a natural objet that has been discovered and described by someone for the first time in a precise period of the scientific development. Accordingly, the question of who firstly discovered it does not apply. Rather, it is the history of the progressive formation of a scientific concept (a nosological entity) which is the product of an interplay between the way clinicians looked at it, and the way patients experienced, self-interpreted and communicated/showed the emotions, cognitions and behaviours attributed to Anorexia Nervosa. Of course, such an interplay cannot happen in void, so the general cultural and social context of the time in which an anorectic was described was intrinsically involved in the way the description itself was made.

A corollary of this stance is that this history self-confines itself in modern times, when a scientific description was thinkable. Speculations about possible cases of anorexia in ancient and medieval times are here avoided because the mind and values of those persons were so different from modern ones that any inference is highly problematic.

The clinical cases that follow are from a book recollecting putative cases of anorexia since the XVI Century (Valente and Aragona, 2017). Here some of them will be used as paradigmatic instances of the different medical and psychopathological views considered, aimed at showing how the theoretical landscape of the observer influences the observed clinical picture. This is not to say that the observer invents the clinical picture. However, the observation of effective phenomena is laden by the way the clinician selects, conceives, and describes them. And these last operations are all influenced by the spirit of the time, the cultural and social background, and above all the scientific question(s) the observer was investigating.

THE MEDICAL QUESTIONS

What kind of medical disease is this? What are its medical features and clinical course? What are the criteria to distinguish this disease from other possible medical conditions? What is its etiology? These questions are typical of a medical model. Regarding cases of self-starvation, several authors have investigated this behavior from a medical perspective trying to answer some of these questions.

One of the first instances can be found in two clinical cases described by Richard Morton (1720). The disease is named Nervous Atrophy, its central symptoms are lack of appetite and consequent weight loss with muscular atrophy (consumption) and amenorrhea, together with increased study. The theoretical question is how to distinguish this syndrome from the similar symptoms presented by patients with tuberculosis or other somatic diseases. The practical question is how to treat them avoiding their death. In the two cases described, the proposed therapies are medical in the first instance (herbal teas and potions), behavioral/nutritional in the second case (ending the studies and drinking milk). In the same century, Robert Whytt (1764) introduced the psychopathological issue within the medical model, describing a young male with a Nervous Atrophy presenting with loss of appetite (converted in hyperphagia during the clinical course), altered digestion, and melancholy. Although it is described that the boy appeared down and thoughtfully, and the title of the book included hypochondriasis and hysteria, the description typically remains a medical record: the rhythmicity of the pulse, hydration of the skin and tongue, problems in digestion, etc. are the main concerns of the author, who explains this syndrome as an effect of ill digestion due to a pathological state of the nerves of the stomach and bowel. A similar stance can be found in every subsequent medical description. For example, when William W. Gull (1868, 1874, 1888) reports his famous cases of Anorexia Nervosa (also named Apepsia Hysterica or Anorexia Hysterica), he stresses the description of them as emaciated young women without tuberculosis. The contrast between refuse of eating and weight loss at one side, and hyperactivity at the other side, is highlighted. True, it is noted that there were also "mental" phenomena, like temperamental irritability, jealousy, and an "ego perversion". However, this is not enough to say that in this way Gull "highlighted the importance of psychological factors behind the disorder" (Niedzielski et al., 2017), because his scripts did not explore further this possibility, while they are full of details about medical symptoms like breathing and pulse frequency, weight, characteristics of urine, etc. Interestingly, Gull refuses the idea that the symptoms may have a peripheral origin (e.g. gastric factors), supporting the alternative medical hypothesis that the disorder has to be related to central factors responsible of the loss of appetite, and in doing so he says that young women are all generally prone to a not better described "mental perversion". So, something mental is evocated but with an unclear role, ambiguously shifting from neurological to mental to even moral interpretations and judgments. In the following years many medical doctors of what we called "the British school" (Valente and Aragona, 2017) will add their own description of cases of anorexia, all of them with a painstaking record of somatic symptoms and a scarce description of mental phenomena. Within this trend, an interesting difference appears in a contribution by Samuel Fenwick (1880/2017), who stresses that the key feature is neither lack of appetite (anorexia) nor gastric pain (as some doctors believed) but the unwillingness to eat. Regarding the differential diagnosis we have again the exclusion of tuberculosis, of the primary disorders of the stomach and also of possible meningitis. Among the etiological interpretations, one is a possible perversion of the nerves of the stomach, showing that the term perversion was used differently than today. Outside the British school, we have another example of this in the concept of "perversion of the sense of appetite" by Giovanni Brugnoli (1875). Finally, many histories of anorexia report Simmonds' discovery of hypopituitarism as cause of extreme emaciation and death as a period in the history of medicine in which a medical model concealed the psychopathological

syndrome. Accordingly, starting from 1914 the clinicians would have progressively neglected the psychopathological dimension of anorexia nervosa in favor of a reconceptualization as neuroendocrine disorder. Considering the force of medical explanations as an attractor of etiological hypotheses, it may be that several cases of anorexia nervosa were misdiagnosed at that times. However, considering the emphasis of the medical model on the issue of differential diagnosis, it is not obvious that girls entitled as possible cases of Simmonds disease were not reconsidered following the evidence of a lack of somatic signs of that disease (exactly as it had happened in more ancient cases, when the hypothesis of tuberculosis was discarded). Accordingly, instances of psychopathological discussion of anorexic cases in the first half of the Twentieth Century were often reported (Valente and Aragona, 2017), so if the Simmonds disease probably influenced the debate, it did not stop psychopathological descriptions.

To sum up, within the medical model anorexia nervosa is "discovered" as a differential diagnosis. Starting from the hypothesis of another medical disease (tuberculosis, etc.), the clinicians realize that emaciation is the effect of a primary refuse to eat, and also note a strange hyperactivity preceding the final cachectic phase. At the beginning they think that such a refuse is due to a loss of appetite (anorexia), a difficulty in deglutition or a gastric pain, only later they realize that the patient is unwilling to eat. Sometimes they also note psychopathological features (irritability, temperamental oddities, family problems) but these are mainly considered as secondary to the medical disease. Having enucleated a primary syndrome independent from already known medical diseases, the next step is to explain its causes, with different hypotheses: primary gastric problems, somatic problems in the mechanism of deglutition, alteration of the nerves of the stomach, failure of the mechanisms regulating the appetite, problems at the level of the central nervous system. The medical treatments tend to be a consequence of the selected hypothesis, i.e. mineral and herbal potions, etc. However, the doctors add pragmatic strategies, mainly behavioral, which appear to be more efficacious, although the death of the patient is not a rare event in the described cases.

THE PSYCHOPATHOLOGICAL QUESTIONS

What are the core symptoms of Anorexia Nervosa? Is a unique concept or there are subtypes? Is it unrelated to other mental disorders, or is it part of a wider syndrome? What are the psychological causes of this disorder? These are typical questions posed by psychopathologists.

Historically, there is not a sharp divide between physicians and psychopathologists, only in more recent times the two points of view diverged more clearly with the establishment of psychology as an individual profession, while until the end of the Nineteenth Century the psychologist were mainly medical doctors studying psychological issues. However, in some authors the emphasis on the psychopathological questions is clearer while the description of bodily symptoms is secondary, supporting a separate description of their views.

To improve readability, the psychopathological issues will be divided in different paragraphs depending on the main concepts driving and shaping the description of anorectic cases.

The construct of hysteria

Hysterical Anorexia is the term used by Lasègue in his famous study published (1873/2016). About one century earlier the same term was used by Naudeau (1789) in a brief description of a 35-years old woman whose starvation originated from a sudden onset of severe pain in the epigastric region. Interestingly, Naudeau directly considers in the differential diagnosis the psychopathological phenomena, stating that the disgust was not explainable by a somatic problem while the "high mobility of nervous nature", the "ethereal constitution", and the "excessive irritation" perceived in the stomach, indicated that it was a hysterical problem.

The descriptions by Ernest Charles Lasègue (1873/2016) are far more reach and complex. He states that the eating problems of hysterics are not just oddities to be merely described, but coherent symptoms presenting themselves similarly in all patients, with same modalities, same mental

attitude, same regular clinical course, so that they can be considered as part of a unitary diagnosis. This disorder has three phases. It starts with mild disturbances of the digestive organs, like disgust and "uneasiness after food", and then progresses through the "conviction that food will prove injurious" to complete opposition and refusal of feeding. In this last phase, symptoms are rigidly structured and stereotyped: i.e. all thoughts, conversation and behaviors are focused on anorexia. So there is a progression from mild bodily symptoms (like pain while eating) to a consequent "abstinence from food" that at least at the beginning is aimed at avoiding the feared pain. However, Lasègue hypothesizes that in typical cases there is a basic emotional problem that the patient avows or conceals (e.g. some "real or imaginary" marriage project, etc.). Lasègue also adds several interesting clinical details to symptom, course, treatment, etc. Regarding course, he stresses that the reduction of feeding is made not suddenly, but by degrees, so that the body habituates itself to the decrease. Also for this reason, he does not observe immediately the expected feebleness, rather the patients appear more active than ever: "this abstinence tends to increase the aptitude for movement. The patient feels more light and active, rides on horseback, receives and pays visits, and is able to pursue a fatiguing life in the world without perceiving the lassitude she would at other times have complained of" (1873/2016, p.27). In sum, at one hand Lasègue is the first who describes in detail the psychopathology of anorexia, considering it as a form of hysteria. Many symptoms he describes are so familiar that we easily recognize a similarity with our patients. He also seems to have largely anticipated psychodynamic ideas about the emotional conflicts at the basis of these symptoms. On the other hand, his cases usually start with a mild somatic distress (we could say a "somatization") and then the food restriction comes as a consequence to avoid further suffering. Respect to this point, his patients are more "hysterical" and "phobic" than nowadays anorectics, so that maybe they could be better diagnosed as DSM-5 cases of "Avoidant/Restrictive Food Intake Disorder". This is a puzzling conclusion, because at one side standard manuals consider Lasègue as the discoverer (usually contemporarily with Gull) of Anorexia Nervosa, while on the other side the DSM-5 criteria for Anorexia Nervosa do not apply to his cases.

In the following years, the descriptions of cases of hysteria with anorexic symptoms will be very frequent in France, including Jean-Martin Charcot (1887), who proposes as part of the "moral treatment" the separation of the patient from family members, and his pupils Paul Sollier (1891), Édouard Brissaud and Achille Souques (1894).

Sollier (1891) distinguishes two forms of the disorder, the first one presenting with multiple symptoms (including hysterical paralyses, etc.) and a "mobility of the psychic state", and a second one defined as "mono-symptomatic form". The latter is characterized by a strong wish to lose weight, together with the "absolute certainty" that food is not required and has to be avoided. In this form, refusal of feeding coupled with hyperactivity is typical, together with indifference regarding surrounding objects and persons, and inability to feel and share emotions that are not related to the unique topic: losing weight. We are still within the construct of hysteria but these symptoms are essentially different from those reported by Lasègue and more akin to our present idea of Anorexia Nervosa.

Brissaud and Souques (1894) talk of a "Delusion of losing weight" to highlight the rigid, fixed idea that starts in a young hysterical girl after some schoolmates criticize her physical appearance. In this case there are also: an interesting oscillation of symptoms between a physical pain and the eating disorder (when her pain increases, the eating behavior decreases); one of the first descriptions of the bulimic side of anorexia ("incoercible vomiting"); a cultural interpretation of the symptoms (according to the patient and her family the disease is due to her onanism); a medical interpretation (the disease is a sequelae of a traumatic hip pain); and a development that the authors consider as a "religious delusion" (she feels guilty and firmly believes that the cause of her disease is that she did not confess her onanism to the priest the

first time, so all the following confessions were invalid).

We can conclude this section with a few sentences from a letter (Gasne, 1900) written by a 16 years old girl, showing another side of the anorexic syndrome which is now considered typical: the use of "tricks" to conceal the refusal of feeding (the patient also used laxatives).

> "Sir Doctor, […] starting from my uncle's threats that either I start feeding or I have to go in a hospital where I will be forced to feed […] I confessed everything […] I admit I had acquired vices, which is shameful […] this is what I was used to do to avoid eating: […]I threw the meat into my handkerchief, […]I had the vice of sneaking off into the cellar to drink my cup of milk, and I did not drink it […] when my aunt was asking "Did you drink your milk?" I boldly replied "Yes, aunt" […] Now the situation has changed within me, I'm determined to eat and I will do it […] I swear to you […] I will eat"

The doctor comments that maybe she was sincere but that the imagination was stronger than the will, so she continued to lose weight. He warns doctors that they have to refuse such patients' promises because they will not keep them.

To sum up, it is within the construct of hysteria, in Nineteenth Century's France, that the syndrome of Anorexia Nervosa, as now we conceive it, is progressively shaped. It started with cases more akin to phobic avoidance of food, for fear of gastric pain or problems of deglutition (hysteric bole). Other hysteric symptoms were present (somatization, belle indifference, fainting, paralyses) and tended to persist in subsequent cases (are they underdetected nowadays?). With time, the core anorexic symptoms appeared more clearly: hyper-valuation of thinness and fear of gaining weight, pervasiveness of this drive, obstinate refusal of feeding, tricks and concealments to avoid the attempts of family members to control and/or persuade the patient to eat, use of compensatory strategies (purging and vomiting, hyperactivity), etc.

It is within the French school that the concept of Hysterical Anorexia is developed, and it is within the same school that it will be reconsidered and resized. In fact, it will be noted that the term Hysteria is used too generically if applied to every non-organic symptom (Debove, 1895), and that there are cases that do not present typical hysterical symptoms (Debove, 1895, Girou, 1904). As we will see in the next section, it is again from within the French school and as a development of the studies on Hysteria that a new interpretation of Anorexia will take place.

The construct of Psychasthenia

Pierre Janet is the recognized father of this concept and a pupil of Charcot, with whom he started his researches on Hysteria. Today Janet is credited for his contribution to the role of traumatic experiences in post-traumatic and dissociative disorders. However, the concept of psychasthenia cannot be understood without considering also the Jacksonian concepts that influenced the idea of a "lowering of mental strength" leading to a progressive disaggregation of consciousness. In this model, the mental symptoms often arise as a disinhibition of low-level functions.

Regarding Anorexia, the first who spoke of psychasthenia appears to be Janet's boss, Fulgence Raymond (1902), in a paper on Hysterical Anorexia. Raymond stresses that one of the two cases here described is very different from those reported by Lasègue. In fact, in his brief case-report there is a sudden intrusion of the idea that the father of this girl would have died if she continued to eat. From that moment, and despite hungriness, she refused to feed. But it is in the case of Nadia that Raymond and Janet (1908a,b) show in detail the role of psychasthenia. Since her childhood, she had an "obsession of body shame" (she felt ashamed for her entire body), which the authors consider as the nuclear symptom from which food refusal and fear of becoming fat derived. The patient writes to Janet that she did not wish to gain weight, or to grow tall, or to resemble an adult woman, because she wanted to remain a little girl for fear of not being loved (interestingly, this reminds us of current psychological theories explaining Anorexia Nervosa on the basis of this fear). The final result is not only weight loss (with increased hunger that the patient tried to control) but a general social withdrawal: the patient remained closed in her flat for fear of being seen and judged, and it is remarked that the patient is not happy for this, she feels compelled to avoid contacts with others. In the same book Janet also describes one

case of "shame of eating", as another variant of psychasthenic scruples leading to food restriction and weight loss.

Although in Janet it is clear the search of differences in symptoms allowing the clinicians to differentiate between Hysterical Anorexia and Psychasthenic scruples leading to Anorexic-like symptoms, it must be noted that there is not always a sharp distinction and sometimes the two syndromes overlap. It is the case of one of the most fascinating clinical cases ever described, the case renamed Renata (literally, *rebirth*), by Louis Schnyder (1912). In this case, eating disturbances (e.g. food restriction, vomiting, weight loss) are mixed together with severe dissociative states, obsessive scruples, and several hysterical symptoms. This French patient spontaneously links her sexual obsessions to several compulsive strategies to neutralize them. Among the related phenomena, there is also what she calls (in English) "Woman-shame-fat", describing in French her typical "obsession of body shame": i.e., she was ashamed of being a woman "from the point of view of the form of the body", always thinking to the way males could think to women. Fatness was particularly unpleasant, because in fatness "the form of the body is particularly evident".

To sum up, in the final part of the Nineteenth Century Anorexia starts to be reconceived as a form of Psychasthenia, i.e. an Obsessive Disorder grounded on sensitive and scrupulous characters. It begins with a tentative of differentiation from Hysteria but with time it is clear that in these anorectics *fin de siècle* symptoms largely overlap. However, this is the occasion to start changing the concept itself of Anorexia: a) it moves from a disorder characterized from lack of appetite and food avoidance due to gastric pain or problems of deglutition, to one in which it is highlighted the active refusal of feeding for mental reasons; b) the obsessive components of the personality start to be described and debated; c) the body uneasiness, i.e. the central role we nowadays attribute to the preoccupation for bodily appearance, becomes a recognized phenomenon.

The construct of Schizophrenia

In past centuries the term delusion had been already used, although sporadically, to characterize the pervasiveness, rigidity and unshakable thoughts of anorectics. For example, Marcé (1859) talked of "hypochondriac delusion", and Brissaud and Souques (1894) of a "delusion of losing weight". However, it is only after Kraepelin's (1893) description of Dementia Praecox that this nosological concept is available as possible frame of reference. The first who conceives Anorexia as a prodromal of hebephrenic Dementia Praecox is Robert Dubois (1913). At the beginning the 16 years old girl described presents with apparently typical refusal of eating and weight loss, which recovers in a relatively brief period of hospitalization (four months). However, one year later there is a relapse, and in the following years a fluctuation between periods of excitement and periods of depression is reported. Nine years after onset, the patient is in an asylum and the clinical picture is severely deteriorated: the patient doesn't recognize the persons, doesn't speak, doesn't eat, is incontinent, is indifferent to the environment. When she speaks, language is incoherent. In other words, the longitudinal observation suggests a "processual" (in Kraepelin's terms) course with a defective outcome which is typical of Dementia Praecox.

Years later the wider Bleulerian concept of Schizophrenia will be used by Ludwig Binswanger (1945) to diagnose the famous case of Ellen West. The onset was at 20, during an holiday in Sicily. It was a nice trip during which she was enjoying the Italian food; she was apparently happy. However, she rapidly gained weight, and her friends started mocking her for this. Immediately she stopped eating sweats and to dine, and began to walk exaggeratedly. For example, when her friends stopped walking, e.g. to enjoy a nice landscape, she continued to walk in circle around them. When she went back home, her parents were alarmed by her thinness. At 23 it started a conflict between fear of gaining weight at one side, and increased desire to eat sweet food at the other side. When she was with others she

could not enjoy food, so she had to eat alone. At 31 she began taking laxatives, alternating periods of food restriction and overeating (nowadays we call this behavior binging). Interestingly, Ellen was visited by the best clinicians of her time and their views diverged. Her psychoanalyst thought she had an obsessive neurosis. Kraepelin based on the evidence of depressive phases and suicide attempts, alternated to periods of elation, his diagnosis of a manic-depressive disease. Bleuler believed she was a case of schizophrenic psychosis with progressive course. Another consultant talked of a psychopathic constitution (i.e., a personality disorder) with progressive development. Nobody diagnosed an eating disorder. Why? Was the diagnosis of Anorexia Nervosa out-of-date, so nobody thought to this possibility for lack of knowledge? Or did they consider eating symptoms as accessorial and/or secondary and were looking for the core diagnosis? Anyway, Binswanger agrees with Bleuler and states that Ellen is a case of schizophrenic "process", proved by "a crack" of her vital development and characterized by a variety of "neurosiform" symptoms as it is often the case in the "polymorphic form" of the *Schizophrenia Simplex*. Independently from the diagnostic quarrel, here it is relevant to emphasize that looking at eating disorders through the lens of the schizophrenia concept probably had a nefarious effect for this case. In fact, at that time the concept of schizophrenic "process" was still partly related to a sort of ineluctable destiny towards the defective outcome. Maybe this had an influence on the decision to discharge the patient from the clinic (although, to be honest, all doctors agreed on this decision, despite their different diagnostic views). Shortly after discharge, Ellen committed suicide! A second remark, decidedly more positive, is that Ellen West is an interesting example of the application of the anthropophenomenological views (*Daseinsanalysis*) to the existence of a woman with eating disturbances. Indeed, independently from the diagnosis, the analysis of her way to experience her *World* (the surrounding world [*Umwelt*], the interpersonal world [*Mitwelt*], and the proper world [*Eigenwelt*]) and her *Time* (time of the ethereal world, the sepulchral world, and the world of praxis) is highly informative of the possibility of such psychopathological analysis to unveil the existential structure underlying eating disturbances.

CONCLUSIONS

The history of the clinical concept of Anorexia Nervosa shows that different clinicians tended to observe and describe different clinical pictures not only because the cases were different, but also because they introduced their theoretical and nosological views in their observation (the so-called *theory-ladenness* of observations). Accordingly, the type of clinical questions the physicians wanted to investigate shaped the consequent descriptions.

The clinical questions were divided in two main families, the medical and the psychopathological questions.

Those approaching the issue from a purely medical point of view tended to neglect (or at least minimize) the role of psychological and psychopathological phenomena, instead focusing on problems of somatic differential diagnosis, measurement of bodily signs and symptoms, organic etiologic explanations, and medical (also behavioral) remedies.

On the contrary, those approaching the issue from a psychopathological stance studied the psychic phenomena in detail, tried to understand the link between symptoms, advanced explanatory hypotheses about the individual, familial, experiential and situational factors leading to eating disturbances, and illustrated various strategies of "moral", behavioral, and psychological treatment.

In this study, at least three psychopathological approaches were distinguished, based on the main nosographical construct operating as a sort of "psychopathological attractor" in a given period of time. Accordingly, in the age of "*la grande hystérie*" (Mid XIX Century), refusal of food and weight loss were conceived as a subtype of Hysteria. At the end of the same century the new Jacksonian ideas in neurology, and the concept of a "psychic tension" molded on that of electric tension (it was the age of the electrification of the cities) lead to the conceptualization of the *Psychasthenia*. From that moment, food

restrictions, fixed ideas about dieting, and weight loss, were conceived in relation to psychasthenic obsessions. Finally, the XX Century is the age of *Schizophrenia*, and even this diagnosis acted as a model to interpret eating symptoms as delusional ideas and bizarre behaviors. It will be only later, with the introduction of the key idea of eating disorders as "psychogenic" in nature, that these syndromes started to be consistently viewed as independent nosological entities (although sporadic claims in favor of their independence were already present in early writings).

Remarkably, the cases of Anorexia we found in different ages show that the clinical phenomena presented were only partly similar. We stressed that the different theoretical views of the observers in different ages influenced the case descriptions. In fact, different views of the observer entail different attention to this or that phenomenon (which can be consequently over or under detected), different interpretations of the same phenomenon, etc. However, the observers' views alone do not explain completely this phenomenon. The impression of the reader is that the patient themselves are different. In some cases described by Lasègue the clinical history begins with gastric pain, and food refusal is an understandable (although problematic) way to relief pain. In some cases described by Janet there are real scruples at the basis of the decision to avoid eating. And in Ellen West mood shifting totally changes eating concerns and behaviors along a phasic course. Are they all cases of the same disorder? Probably not, and this independently (although inextricably intertwined) from the aprioristic theoretical views of the clinician.

Finally, "below" this variance, the details of the symptoms of Anorexia as we currently conceive it slowly emerged. Not only food restriction and weight loss, but also pervasiveness of the drive to thinness, body shame and sensitivity to the other's judgment, perfectionism, hyperactivity, use of purging and vomiting strategies, etc. etc. It is as if the final picture emerged slowly, every new description noting a detail veiled until that moment. However, we have also to remind the reverse: in any new description some details previously noted were no more reported, so while something was unveiled, something else was concealed. This is relevant because reminds us that the current criteria of Anorexia Nervosa do not show the definitive, real clinical picture of a natural entity, but the last development of an Idealtypical concept. As anorexia changed in different ages, probably also future anorectics will not be the same as today's (Valente and

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